

POSLINK

The Newsletter of People Living With HIV/AIDS Victoria



John Daye says goodbye at the PLWHA Victoria AGM after 8 years as President

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World AIDS Day 2004

The following is a speech by PLWHA Victoria's President, Greg Iverson, at the Positive Living centre.

This year's theme for World AIDS Day as we all know is Women and Girls.

There can be no denying that this is an area that is often overlooked in the AIDS epidemic, both internationally, but more importantly for organisations such as ours, here within Australia also.

There is no doubt in my mind, that for the public by and

large in our country, AIDS is still seen as a 'gay man's disease'. We all know from personal experience this is not the case. It is beginning to be acknowledged by the public perhaps, that this is not the case in third world countries. Globally, just under half the HIV positive population are women and girls. In some places, for example Africa, this figure is 60%.

Often for women and girls, the health crisis is made worse by the status of women within those societies, where their

positions are traditionally weaker.

Asia is on its way to overtaking the African sub-continent in the numbers of HIV positive people, and it is widely anticipated that it will be women and girls worst affected in that region.

There is already an obvious and rapidly expanding crisis in Papua New Guinea and again, women and girls are emerging as the most affected group.

Too many people are suffering in the third world where there are medications

(Continued on page 8)



President

Greg Iverson

Vice President

David Menadue

Secretary

Brett Hayhoe

Treasurer

Stephen Eustace

Positive Women Rep

Suzanne Lau-Gooley

Straight Arrows Rep

David Beech

Board Directors

Daniel Donnelly

Pat Garner

Rebecca Matheson

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Note from the Executive Officer Mark Thompson

Since our last Poslink issue, PLWHA Victoria held its Annual General Meeting and elections, resulting in some major changes in the board. For the first time in eight years, John Daye did not stand for the board and the organisation now has a new president, Greg Iverson, whose first report to you is in this issue.

The new board comprises:

Greg Iverson *President*
David Menadue *Vice-president*
Brett Hayhoe *Secretary*
Stephen Eustace *Treasurer*
Neville Braybrook
Alby Clark
Daniel Donnelly
Pat Garner
Rebecca Matheson
Tony White
David Beech *Straight Arrows representative*
Suzanne Lau-gooley *Positive Women representative*

Attendance at the AGM was one of the largest we have had, a tribute, no doubt, to outgoing President John Daye. With many representatives from other organisations and a large number of members present, the organisation paid tribute to his leadership and vision over the last eight years and presented him with the inaugural Exemplary Service Award. While John's work now takes him into national and international areas, his expertise and knowledge will not be lost to us, and he will continue to be a valued member of the organisation contributing to groups such as the Health and Treatments Reference Group.

Other changes to the organisation include new staff

members and a new role for an existing staff member.

Many members will know Suzy Malhotra through her organising of our Treatment Interactive Events. Suzy has now joined the team as Community Development and Education Coordinator, with the dual responsibilities of supporting and developing the board in its representational role and development of the membership plus implementing the positive education project over coming months.

Frank Dimitriou has been appointed part-time Administration Assistant and Max Niggel has been appointed to the new stand-alone position of Speakers Bureau Coordinator, which means that the Speakers Bureau will be a major focus of the organisation's work into the future.

Office Holiday Hours

The office team will be taking a short break over the Christmas-New Year break and will close from 12 noon on Friday 24 December and reopen on Tuesday 4 January 2005. From all the team, we hope you have a happy and safe holiday. 2005 promises to be a busy year for PLWHA Victoria and we hope that you will be a part of all that we do.





Note from the President Greg Iverson

I should start my first President's report by doing

two things. The first is to acknowledge the work of the board members who have left us last year.

Guy Kharn is well known to many of you through the Positive Plots project. Apart from his regular board duties, I want to make special mention of the hard work that he and his partner Steven put into this valuable project. Whilst Guy is no longer on the board, he is still running Positive Plots for PLWHA Victoria and he is currently looking for opportunities to expand this project into other areas of Melbourne.

Kevin Guiney has served on the PLWHA Victoria board for many years - a lot of those as our Treasurer. He is now serving as the President of the Victorian AIDS Council Board.

And of course, our former President of many years, John Daye. There is not enough room for me to write on all of John's achievements. Like the others mentioned above, although John has left our board, he still retains close ties with our organisation. John will continue his role with NAPWA as the National Treatments Convenor. John has also begun important work in a role on the committee of the International Treatment Preparedness Project, where his wealth of knowledge, experience and his dedication to the cause of equitable access to HIV drugs for PLWHAs internationally will be well utilised.

John has (though he would not admit this) left a huge space to fill in this organisation and if I can do half of what he has done in my term as President,

then I will consider my time at PLWHA Victoria well spent.

I would also like to welcome the new members to our board this year with the addition of Rebecca Matheson, Neville Braybrooke and Tony White.

The second thing I should do is to let you know a bit about myself.

I sero-converted in 1985. I consider myself fortunate to still be here and still be relatively healthy. Like most of us that have been around for that long, I have lost many people to this epidemic.

I have been through anger, sorrow, fear and relief.

I have seen the health system first hand with the dedicated GPs with high HIV case loads, to the other end of the spectrum with health professionals who out of fear and ignorance, wouldn't treat a positive person.

I have had some good times and some bad times; healthwise, workwise and just living in general.

But it has made me tough and a survivor.

I believe in standing up for the right to have some say and approach in the responses made around this epidemic.

And why not? I am intimately related to how it feels to be discriminated against because of my positive status, on the side effects that a HAART regime can bring and on the gamut that all PLWHAs have had to run over the years.

And I am looking forward to the challenges that lie ahead in my role as President.

We have an exciting year ahead of us at PLWHA Victoria. After many years, we have finally gained funding from the Department of Human Services and recognition that PLWHA

Victoria should be seen as an autonomous organisation. We thank the department for its trust in our body and we look forward to this expansion of our services and advocacy roles that the funding has made possible for us.

Thanks to this funding, we have been able to restructure our office. This has included the hiring of a new Administration Officer, Frank Dimitriou and the upgrading of Max Niggli's role as the Speakers Bureau Co-ordinator to a four day per week position. This ensures that Max's excellent work to date can be expanded and allow the Bureau to grow even further.

As well, we have been able to create a totally new position in the organisation, a Community Development Officer. We were fortunate to get Suzy Malhotra to take on this role. Suzy's name will be familiar to many of our members as she has successfully worked on projects with PLWHA Victoria before.

We have many projects planned for next year. Some have already commenced, such as our *Genesis* program.

Genesis is a forum for recently diagnosed people (around 2 years or less), concentrating on issues around health information, living well with HIV, the immune system and treatments, disclosure, positive sexuality, sexual health and safer sexual practices. The program will help to orient people to their HIV diagnosis and connect them with the various HIV services available in Melbourne. The first program ran for 2 Saturdays in December and will be repeated every 4 months, depending on demand.

Another project that is starting early next year is the Positive Education project. This

Note from the President

project is called 'The Words to Say It'. It is designed for HIV-positive people, aiming to address their health and well-being needs, and to develop their knowledge and skills around safe sex negotiation — with the objective of reducing HIV transmissions.

It includes forums for both positive and negative gay men on sex, disclosure and negotiation. Also, for the first time, and in conjunction with the Country AIDS Network, a forum will be held around increasing positive awareness, sexual health and HIV transmission for rural people in Bendigo. Another important part of this project is a planned forum for Positive Women and one for heterosexual positive men, around these same themes.

So if you would be interested in attending one of these forums, then ring our office on 9865 6772.

Service provisions like these and other activities that we are continuing in and expanding are just an aspect of our work though.

Advocacy is another important area. We will need to be very active in the times ahead in this field. There can be no denying that there is a distinct air of conservatism creeping into politics at the moment. This is particularly evident on the Federal level. Many issues will have to be watched over carefully in the coming months and this is an area that we recognise will take a lot of our energy and focus.

There is a perception in the HIV community sector that moves to a 'devolving' of the very successful 'partnership' approach seems to be occurring. This is a worrying state of

affairs and is one area that we will have to watch closely over the coming years. We must fight to hold on to this model which has proven its success over the years.

Another major issue that we will be tackling in the very near future is that of the Housing crisis for PLWHAs. This is an issue that has recently had a review, but the refusal by the Department to even release this review has the community very concerned. Action is being planned on a response to this by VAC, AHAG and PLWHA Victoria.

We also have the aim this year of further encouraging our members to become more involved in our organisation and

it's activities. Whether that means joining us in the Pride March under our banner, coming to one of the events mentioned above or to one of our popular Treatment Interactive Events or Planet Positive social nights, or simply contacting our office with some advocacy issue that you would like to see us pursue — we would like to hear from our members more this year, as our organisation can only be as strong as the input that we receive from our members.

I hope that this year, which is a year that will see our services and advocacy grow, will be a satisfying and rewarding one for our organisation and for all PLWHAs in Victoria.

JOIN US WITH PRIDE

PLWHA Victoria is calling for members, their friends and family to join us for Pride March 2005.

Last year was our biggest contingent yet, with over 30 participants, and the uplifting and supportive response we received from the crowd and other marchers was truly inspiring.

We will look great again this year, with colourful banners, flags and T-shirts.

Pride March is on Sunday 30 January 2005 starting at the Corner of Lakeside Drive and Fitzroy Street. Gather at the park from 4.00 p.m.

To register your participation in the PLWHA Victoria contingent call us on 03 9685 6772 or email info@plwhavictoria.org.au or you can turn up on the day.

What's Up, News and Information

3 new drugs now available on the PBS

2 new protease inhibitors and the Roche fusion inhibitor and now available by prescription at HIV pharmacies:

Fosamprenavir

Fosamprenavir (Lexiva), a protease inhibitor, is a new formulation of amprenavir that has been around for a few years. The old amprenavir formulation dosing schedule was 8 x 150mg tablets twice a day without ritonavir. The new fosamprenavir formulation can be dosed with 2 x 700mg tablets once a day with 2 x 100mg ritonavir capsules for people who have not taken protease inhibitors previously, or 1 x 700mg tablet with 1 x 100mg ritonavir twice a day for people who have had protease inhibitors previously. Studies of fosamprenavir with ritonavir show a low resistance rate.

Atazanavir

Atazanavir (Reyetaz) is considered to be a second generation protease inhibitor which means that....it's different! It is the first protease inhibitor that does not interfere with the metabolic processes of the body such as those associated with lipodystrophy (big belly, buffalo hump, high cholesterol and high triglycerides) or glucose intolerance that can lead to diabetes. It is also the first truly once daily protease inhibitor to enter the HIV market. Atazanavir must be taken with food and is dosed once a day either as 2 x 200mg capsules without ritonavir or 2 x 150mg with 1 x 100mg ritonavir. The ritonavir boosted atazanavir appears to be as potent as Kaletra and has fewer side effects than Kaletra. The only

draw-back with atazanavir is that bilirubin (a breakdown product from red blood cells) can increase in the blood, which may result in some people getting yellow skin or eyes. The increase in bilirubin does not interfere with any bodily functions and is considered to be a safe side effect.

T-20

The fusion inhibitor T-20 (Fuzeon, enfuvirtide) has revolutionised HIV medicine. It is the first protein molecule of its kind to ever be developed which has lead Roche to receiving the prestigious 2004 International Prix Galien for the most innovative new medicine. T-20 stops HIV from entering into cells. As it is able to treat HIV outside of cells it also means that it is unlikely to have side effects like other HIV drugs. And this has proven to the case. It's side-effect profile is quite remarkable. It appears to be a clean drug that is highly potent

at inhibiting HIV. However, being a protein molecule, it has to be injected under the skin twice a day. The injection result in a painful injection site reaction for most people, with some swelling that can last for a few days. The swelling can lead to the development of scar tissue that can become quite hard over many months to years of injecting in the same places. The other side effect from T-20 which is not understood is that there appears to be an increased rate of bacterial pneumonia in a few people. Putting the injection site reaction aside, T-20 offers new hope to people who have developed resistance to, or who are intolerant to many of the currently available drugs. T-20 won't be for everyone and does require an aspect of motivation for self injecting which doesn't appear to be a problem for people taking it. Roche has provided excellent education and training for health care workers to enable them to provide support to T-20 patients around the injection processes.

PLWHA VICTORIA WEB SITE

People Living With HIV/AIDS Victoria is looking for members interested in helping develop the PLWHA Victoria web site.

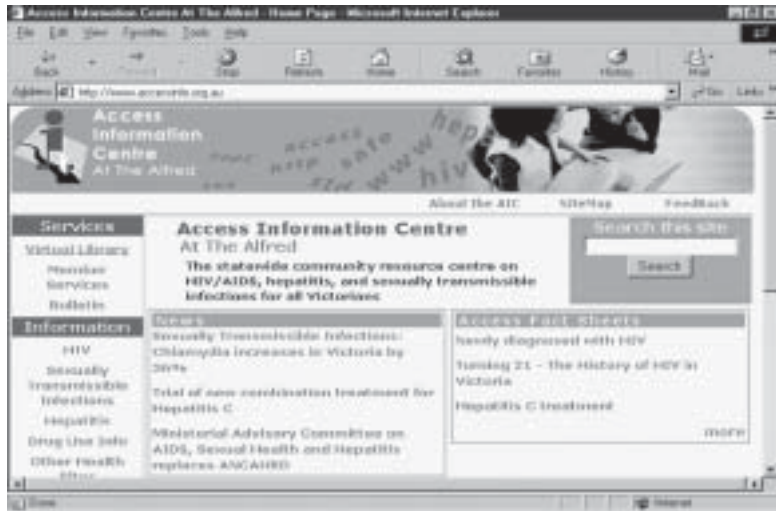
If you are interested in design, writing, planning, testing or just using the Internet, we need your contribution to develop the next exciting phase of the PLWHA web site.

To register your interest, call or email the PLWHA Victoria office 03 9865 6772 or info@plwhavictoria.org.au

A meeting will be arranged in the new year to plan the new site.

What's Up, News and Information

Access Information Centre (AIC) has a change of face!
www.accessinfo.org.au.



Liza Doyle and Jenny Stewart at the Access Information Centre

The Access Information Centre (AIC) is very excited to announce the appointment of two new staff members, Liza Doyle and Jenny Stewart. To ensure the Centre's makeover was complete, the AIC website has undergone a few modifications to enhance its ease of use and appearance.

Liza Doyle is the AIC Coordinator and has extensive experience in health education and training across a range of environments both here in Australia and South East Asia. After completing her nursing training, Liza undertook a Graduate Diploma in Health Science and has recently completed her Master of Public Health through Monash University. Earlier this year, Liza was involved in organising the 15th International Conference on the Reduction of Drug Related Harm. Liza has a strong interest in blood borne viruses and a belief in the delivery of health information and services that are practical, accessible and acceptable to all members of the community. Liza is looking forward to working with the community to ensure the delivery of a valuable and

effective HIV/AIDS, Hepatitis and Sexually Transmitted Infection (STI) resource service.

Jenny Stewart is the newly appointed Librarian and has a background in the community health sector. Jenny has worked for over 10 years as the Coordinator of an information service, which focussed largely on issues of cultural diversity. Jenny is an enthusiastic appointee and is available to assist members of the community locate a range of Hepatitis C, HIV/AIDS and STI resources and information, including conducting literature searches and the posting out of relevant information and materials.

For those unfamiliar with the Access Information Centre, it is a free statewide community resource centre for HIV/AIDS, Viral Hepatitis and STIs. It is open to all members of the Victorian community and operates as a drop-in centre from Monday to Friday. The Centre is managed by the Alfred Hospital and has an extensive range of materials including brochures, books, journals, training manuals, videos and posters, including access to

online databases such as Medline. Jenny & Liza are available to assist visitors find information and show them how to use the AIC computers to search the Internet and the AIC virtual library catalogue.

The AIC website is user-friendly and provides members of the Victorian community with easy to read fact sheets, links to related sites and the ability to check out the virtual library catalogue, including a request information. Please check out the new Access Information Centre website and feel free to give us your feedback. Keep a look out for regular updates on the latest information and expansion of services available. For people who are unable to visit the centre or do not feel comfortable doing so, we can answer questions over the phone, via the website or send out relevant information or resources. The AIC web site address is:

www.accessinfo.org.au.

Happy surfing and we look forward to hearing from you!

Acknowledgement: This article was supplied by Jenny and Liza.

What's Up, News and Information

HIV Futures 4: The State of the [Positive] Nation

By Mark Thompson

Earlier in 2004 PLWHA Victoria participated in the distribution of the Futures 4 survey. The most comprehensive survey of HIV positive people in the country, Futures 4 is the work of the La Trobe University's Australian Research Centre in Sex, Health and Society and chief investigator Dr Jeffrey Grierson.

This year more than 1000 Australians from diverse backgrounds and ranging in age between 18 and 92, completed the survey, reporting on their health and well-being, their medical care, economic circumstances and sources of support.

Key findings of the 2004 report are that, despite the fact that 71% of people with HIV are on some version of the anti-

retroviral treatments which have made the disease more manageable, at least 77% of them are experiencing difficulties with the treatments.

"This is consistent with the findings from previous surveys," said chief investigator Dr Jeffrey Grierson, "and reminds us that we are far from having a solution to the problem. When you add to this the finding that 44% of this sample has another major health condition, such as cardiovascular disease or Hepatitis C, it is not surprising that HIV is still having a major impact on people's lives."

"We were also concerned," said Dr Grierson, "that 27% of people with HIV are living below the poverty line, in most cases as a result of the impact of the disease. This is something which

indicates the importance of ongoing government support for the community agencies which play an important role in assisting and advocating for people with HIV all over Australia."

Research like Futures 4 is vital for community organisations as it provides the evidence when arguing for policy change or improvements for HIV positive people's lives with government and industry. In addition to the main Futures report, ARCSHS also publishes special papers concentrating on specific areas of the survey and is also able to respond to community organisations' special inquiries.

The full Futures 4 report is available at www.latrobe.edu.au/hiv-futures

What was your experience of being tested HIV positive like?

As HIV social workers at The Alfred Hospital we have heard many stories from people living with HIV/AIDS about their experiences of getting tested for HIV. It seemed to us that all too often what we were hearing gave cause for concern, with great inconsistencies in how people were prepared for the test and given the news afterwards. Did anyone talk to you about the chances of a positive result, and what would you do? When you were told you were HIV positive, what sort of counselling support were you offered? Some people remembered their diagnosis vividly, and held on to the experience of feeling judged, of being given a 'death sentence', of being turned away. Others reported that they received good counselling support and that this assisted them to better manage and get on with their lives.

We believe people's experiences of getting tested HIV positive need to be heard. We shared our idea with researchers from ARCSHS that these inconsistent experiences of pre and post test HIV counselling may have an impact on a person's longer term health and well-being. Together we are taking the opportunity to ask people to share their recollections of getting tested for HIV in order to research the value of such counselling. If you would like to be part of this exciting project please reply to the adjacent ad. Your support is much appreciated.

Volunteers needed for research study

Researchers from ARCSHS, La Trobe University and the Social Work Department, Alfred Hospital are seeking volunteers to participate in focus group discussions around the experience of HIV testing and diagnosis.

To qualify for the study you should be:

- J HIV+ (male or female)
- J diagnosed in Victoria
- J willing to share experiences

The focus group will take place at the Positive Living Centre and will run for about 2 hours. Confidentiality will be respected and assured. Refreshments will be provided and participants will be paid \$25 for their time.

For further information or to register your participation contact:

Kirk Peterson at ARCSHS on 9531 3472
Or by email k.peterson@latrobe.edu.au



available, but not affordable, to assist them. It is even harder if you are a women or a girl trying to access these medications in those settings. Let us hope that this year's theme has focused attention on this area at least.

Some of the above issues have recently been featured in the mainstream press, which is a good thing. The shame of all this coverage is that it is only there because of World AIDS Day events, and it will soon disappear into the quagmire of the pre-Christmas press, rarely to emerge again until this time next year.

It is an obligation on us, living in a western society with all of its benefits, to not just advocate for the issues that are personal and at home, but also those that affect the HIV population world wide. The growing international crisis needs to be constantly re-stated, not just within our own sector, but to the wider public all year round.

Unfortunately here on a federal government level, the attention span given to these issues is not much better. The fact that our government has done very little until recently in even beginning looking at the emerging crisis in PNG, is a matter of some shame for our country. We have an obligation

to assist PNG and the Asian region, if only for the reasons that they are our neighbours and that as a western society, we can afford to.

It has fallen to organisations such as NAPWA, AFAO, Positive Women and other state based PLWHA organisations like ours to actually begin attempts at assistance for places like PNG.

At least the recognition is starting by government and the public that in these overseas settings, HIV/AIDS is as big a problem for the heterosexual, as well as the homosexual, community.

But strangely here at home, HIV/AIDS is still often talked of only in terms of gay men by these same sectors.

This is a perception that we obviously must change and actively work against as advocates. PLWHA Victoria represents all positive people in this state, not just gay positive men, and this crisis is not solely confined to the gay community.

It is true that as a positive man, I do have much in common with my positive sisters; but to deny that there is a raft of differences in our experiences of HIV/AIDS - differing support needs, complications, side effects, effectiveness of treatments just to name a few things - would be to deny the truth.

The experience of being HIV positive for women, while having basic commonalities with the larger positive male population, is a very different one.

Issues around childcare; retreats for HIV positive people and their children — both negative and positive; assistance for positive women who wish to become pregnant and raise families; research into the differing medical effects that HAART has on the physiology of women, are all examples of issues that would not feature highly on the general HIV agenda in the past.

But they are important ones and cannot be ignored.

To say that nothing has been done in any of these areas is wrong, but to say that anywhere near enough has been done is even further from the truth. More advocacy must be addressed to these areas.

Today PLWHA Victoria inducted Sonya Ristov into the *Legends* series. *Legends* is a collection of storyboards with a photo and a short biography of some of the many positive people who have dedicated so much of their time and energy to the community for the benefit of all.

Sonya was a long-term member of Positive Women and was a great influencer and

(left) At the PLC World AIDS Day event, Sonja Ristov was inducted into the PLWHA Victoria 'Legends' series that acknowledges people who have shaped our history. Present are Greg Iverson and Sonja's mother, Selma Ristov. Legends is on permanent display at the PLWHA Victoria offices



example for HIV affected women in Victoria. She was a fierce advocate and a powerful voice for positive women's issues. We are pleased to be able to include Sonya in this important record of HIV/AIDS activists in Victoria.

Also at PLWHA Victoria, we recently received funding for our Positive Education program. It is designed for HIV-positive people, aiming to address their health and well-being needs and to develop their knowledge and skills around safe sex negotiation – with the objective of reducing HIV transmissions.

It includes forums for both positive and negative gay men on sex, disclosure and negotiation; also, for the first time and in conjunction with the Country AIDS Network, a forum around increasing positive awareness, sexual health and HIV transmission for rural people will be held in Bendigo; and another important part of this project is a planned forum for positive women and one for heterosexual positive men, around these same themes.

While normally all of our events are meant to be inclusive of the whole HIV/AIDS community, there is a recognised need for separate events such as these. If funding continues for this project, I believe that these particular

forums can and should become regular events.

In the context of the apparent growing conservatism within federal politics at the moment though, and the worrying apparent moves on the 'devolving' of the partnership structures within the HIV Sector, the time we will have to spend just defending and maintaining our current services and education strategies will be great. The bringing to the attention of government departments and drug companies even more issues that they must look at is not going to be easy.

But it is needed and let's face it, that is one of the main reasons that we are here in the first place.

Recent comments made by the Prime Minister in relation to the growing international HIV/AIDS crisis in our region, recognition by the department that the 5th National Strategy needs to be re-worked, and their agreement that an STI strategy needs to be a separate document, are all hopeful signs that our messages are getting across, but we need to keep the advocacy up on these issues to ensure that they are followed through with the appropriate action.

PLWHA Victoria this year welcomed another member of

Positive Women on to our board, Rebecca Matheson. It is always the aim of PLWHA Victoria to maintain and strengthen the already solid ties between our sister and brother organisations, Positive Women and Straight Arrows.

The contribution of Rebecca and the other Positive Women's representative on our board, Suzanne Lau-Gooey, can only help in giving a stronger voice to the particular issues that positive women and girls face in this crisis, and we look forward to bringing these issues even more into the advocacy and education role that we play at PLWHA Victoria.

I would like to finish by saying that this day, World AIDS Day, is an important event for PLWHAs everywhere — no matter what the theme. As I said above, it is a pity that the focus on this crisis that some think is over, is only there once a year — but at least it is there then.

It is up to us, all of us, within the HIV/AIDS community, to ensure that the focus is on the issues that are affecting our lives, happiness and well being all year long and not just on this one day of the year, important though this day is for us all.

Thank you

What's Up, News and Information

PLWHA Victoria awards at this years AGM

Recognising contributions to HIV-positive people in all sectors, from volunteering to research, the Annual Awards are a way of highlighting the enormous amount of work, paid and unpaid, that continues to be needed for HIV-positive people and to recognise the people and organisations whose efforts in their particular area have been exemplary.

Of particular interest are the new Awards for contribution to the PLWHA Victoria Speakers Bureau and the special Exemplary Service Award made to the outgoing President of PLWHA Victoria, Mr John Daye.

A total of fifteen awards were presented to the following people and organisations:

President's Award

*The Hon Bronwyn Pike MP, Minister for Health
Michael Rogerson*

HIV Sector Partnership Award

The Events Team, Victorian AIDS Council/Gay Men's Health Centre

Clinical Excellence Award

Dr Edwina Wright

HIV Media Awareness Award

Paul Kidd

Volunteer Commitment Award

Colin Krycer

Community Endeavour Award

*Jeffrey Robertson
Steven Wiggins*

Enabling Sponsor Award

South Yarra Volkswagen

Speakers Bureau Award

Marie Frodsham

Special Acknowledgement Award

*Kirk Peterson
Andrew Timmins
Max Niggel*

Legend

Sonja Ristov

Exemplary Service Award

John Daye

What's Up, News and Information

PLWHA Victoria awards at this years AGM



What's Up, News and Information

Positive Education 2005 – A Year of Action

In November of this year People Living with HIV/AIDS Victoria received funding from the Department Of Human Services for the position of a Positive Education Officer (Suzy Malhotra) to develop an education program for HIV-positive people in Victoria. The project aims to provide relevant information around sexual health to PLWHAs and to develop skills around issues of sexual negotiation and disclosure – with the goal of improving the health and well-being of HIV-positive people and in this process, contribute to a reduction of potential HIV transmissions.

The 'Words to Say It' campaign will be launched during the Midsumma Festival and will undertake an education program consisting of a number of courses/events focusing on the prevention of HIV transmission and will be aimed at exposing and challenging attitudes towards HIV-positive people. It will also feature forums for both positive and negative people on sex, disclosure and negotiation.

The first of these forums will focus on the sometimes contentious subject of barebacking. This will be one of the first times in Victoria that HIV positive and HIV negative gay men will be in the same room talking about what sex means to them. *'Barebacking and Nail-biting: A Hypothetical about Sex, Pleasure and Other Catastrophes'* will be a timely but humorous exploration of contemporary gay life and sexuality.

The complexities of sexual risk reduction among gay men (regardless of HIV status) have not been part of public discussion. Fears of media sensationalism and demonising gay men further restrict attempts to promote constructive and thoughtful public discussion on the issue of barebacking. Since the effectiveness of health promotion campaigns depends on their being seen by their target audience to be relevant and motivating, PLWHA Victoria will provide the opportunity for PLWHAs to contribute to these discussions.

Throughout summer, PLWHA Victoria will also be participating in public events such as Pride March and Midsumma Carnival using the 'Words to Say It' message. Further, we will be collaborating with the Country AIDS Network with a regional forum in Bendigo towards the mid-year.

The particular needs of positive heterosexual men and women will also be addressed with forums and workshops planned in collaboration with Positive Women and Straight Arrows which

will focus on body image, relationship and disclosure issues, especially to children.

This education campaign has been made possible by a grant from the BBV/STI Unit of the Department of Human Services and is based on the 'Words to Say It' campaign developed by Health Promotion, People Living with HIV/AIDS (NSW).

We'd certainly like to encourage all our members to become more involved in what will no doubt be an extremely eventful and exciting year ahead. Whether that means joining us in the Pride March or attending one of our lively events, we'd welcome your attendance, feedback or contributions to this exciting project.

Barebacking and Nail-biting: A Hypothetical about Sex, Pleasure and Other Catastrophes'
Sunday 6 February 2005 – St Martin's Youth Theatre, South Yarra

Pride March
Sunday 30 March 2005 - St Kilda

Interactive Event – Sexual Health
April 2005 - Country AIDS Network, Bendigo

Interactive Event for Positive Women – Disclosure, Body Image and Sexual Health
May 2005

Interactive Event for Straight Arrows
May 2005

Congratulations Sarah Garner

Sarah is a volunteer at PLWHA Victoria, providing guidance to the organisation through our Health and Treatments Reference Group

Sarah has just finished her medical degree, graduating from Monash University on 2 December, 2004.

Lifestyle Hints and Tips

Partying safely over the summer period

By Alan Strum

Summer is upon us and the party season has begun. It's time to go out and have some fun! For some people this will mean BBQs or picnics with friends, walks along the beach, evenings at the pub, dancing in clubs or maybe going to some of the major dance parties around town. There are many ways to enjoy yourself. Choose your activities and HAVE FUN. However, having fun for some people might mean wanting to take recreational drugs such as speed, crystal or ecstasy. Recreational drugs alter the chemistry of the brain resulting in the release of 'happy' chemicals (neurotransmitters) or other chemicals that can increase energy. There is of course the old saying, 'what goes up – must come down'. PLWHA Victoria does not endorse the use of recreational drugs. Recreational drugs can cause harm to people and may result in addiction. Not taking recreational drugs is the best way to avoid possible harm.

The following information is provided as a public health message to reduce possible harm that could be caused by recreational drugs for people with HIV.

Drug interactions

People with HIV who take recreational drugs need to be aware that there are drug interactions that can take place between some of the HIV drugs and the recreational drugs. Protease inhibitors like Kaletra (and others) can inhibit an enzyme in the liver that is meant to break down foreign substances in the body. Recreational drugs are foreign substances. This means that recreational drugs won't be eliminated from the body in the same way as someone who is not taking HIV drugs. This can result in an increase of the recreational drug where too much drug can get into the body and hang around for a much longer period of time. There are reports that HIV drugs cause the body to absorb up to 10 times more than the normal amount of recreational drug. This can result in overdose. The drugs that are known to be associated with overdoses are amphetamine based drugs like speed, crystal or ecstasy. The overdose can be life threatening. It might also take longer to come down from the drugs so planning your recovery may be important.

Helpful hints

- 📖 Shop for your recovery
 - o Have lots of easy to eat foods waiting for you when you get home like porridge, yogurt, soft fruits, milk, protein shakes, Sustagen, soups, ice cream etc.
 - o Get some DVDs from your local video store so you will have something to entertain you while you relax after your party.
- 📖 If you know you won't be able to sleep after a big night out, talk with your doctor about how to manage this before hand.
- 📖 Plan your HIV drug schedule to avoid missing doses. You never know, you might meet that special person on the night or morning after. Take spare doses with you to the party.
- 📖 Don't stop taking your HIV meds as the virus can develop resistance to them. Any breaks from HIV meds should be discussed with a doctor or treatments officer before hand.
- 📖 Separate doses — don't take a recreational drug at the same time as your HIV meds.
- 📖 Less is more — take baby doses of the recreational drugs and wait to see how you go.
- 📖 Share with your friends — let your friends know what you have taken just in case you need help.
- 📖 Drink plenty of water, especially if it is hot and you are dancing lots.
- 📖 Seek medical assistance if required — overdoses are treated as a medical condition.
- 📖 Don't take drugs and drive — drugs impair judgement. It is illegal to drive under the influence of drugs.*
- 📖 Have plenty of rest even if you can't sleep.
 - o Exhaustion and drugs can result in irrational behaviour and paranoia (psychosis) in some people. Seek medical attention if required or talk with your doctor about ways of preventing or managing this before you go partying.

* The Victorian Police do random roadside tests for amphetamines and marijuana. The THC component from marijuana or cannabis will be detected by the saliva test for several hours after consuming the drug. However, there are a number of variables that affect this such as the dose consumed, the potency of the drug and a persons individual metabolism. The test is not designed to pick up trace elements of THC that may have been consumed from previous days. The test is also designed to detect speed or crystal (methamphetamines). Ecstasy tablets may also contain methamphetamines. Amphetamines will show a positive result for a minimum of 24 hours after consuming the drug. Once again this will vary from person to person. For further information visit www.arrivealive.vic.gov.au.

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Special Feature

Rolling out Antiviral Drugs in Botswana Dr Jonathan Anderson shares his experiences working with 'Doctors without Borders' in a remote area in Botswana.

Botswana is a dry and dusty country in southern Africa made up of Kalahari desert scrub and the vast Okavango river delta area full of wildlife. Over 34% of adult women are HIV positive. 300,000 of the total population of 1.8 million are thought to be HIV positive. I recently spent three months helping out in the start up phase of an antiretroviral clinic in a small village hospital in the northwest of Botswana near the Okavango delta. It was 1000 km away from the capital Gaborone and 250km from a town big enough to have a bank.

My role was to help train local doctors and nurses in HIV care and to act as a clinical mentor as they started using the ARVs for the first time. I also helped advise the local medical and nursing leadership on the best system to implement the national ARV program at the local level. I wasn't there to take over or to see patients myself, but inevitably I got involved when staffing levels were stretched.

First off why does Botswana have such a high rate of HIV infection? Some people would say that it was related to men going away to diamond and gold mines as well as cultural practices such as the tradition that young women will become pregnant early in life to prove their fertility before they get married. Government policies which post public sector workers such as nurses, teachers and police far from their home villages around the country may have spread the infection far and wide.

Most transmission of HIV seems to occur by heterosexual transmission. Gay sex is illegal so good statistics on this are hard to find. Pregnant women



may also transmit HIV to the children even though there has been a program to prevent the transmission of the virus from mother to child for a number of years using short courses of AZT and single dose nevirapine.

Around 6000 people with HIV live in the area served by the hospital and the district health clinics. They live in houses made of mud and reed in villages of up to 11,000 people. One of the villages with a satellite health clinic was 250km away from the hospital across the river delta. When patients needed to be taken to hospital they were taken by a water ambulance for the first hour and a half through channels infested with crocodiles and hippos.

The local people survived by living off the dry scrub land, fishing in the river, keeping cattle, donkeys, goats and chickens. Land is held in common by tribal groups. If someone wants to build they seek the permission of the local chief who allocates them the place to build a house. Extended families support each other through times of adversity and there's a system of food parcels

for those who were completely destitute. But few people own cars and so they rely on hitching a lift in a government vehicle or truck or take the daily but irregular bus.

There are just six doctors for the 60,000 people living in the area. Not only do they have the problems of people living with HIV to deal with, but they also run the general outpatient clinics, look after the inpatient ward, do surgery and help in maternity with difficult births. Nurses take a very prominent role in the running of the district health clinics and associated remote health posts with fortnightly support visits from the doctor.

There are extensive campaigns in Botswana to educate people on preventing HIV by using condoms. Billboards in every town encourage people to have antibody tests for HIV by visiting the local clinic to see the lay counselor who conducts the pretest counseling and orders the test. When the result comes back, it's given by this lay counsellor.

Special Feature

Rolling out Antiviral Drugs in Botswana



treatment failed, the second line was Didanosine, Stavudine and Nelfinavir although this is about to change in the 2004 guidelines to Abacavir, Didanosine and Kaletra.

Many people came to the clinic quite sick with HIV wasting disease, oesophageal candidiasis, PCP and chronic diarrhea. One of the most rewarding parts of the experience for me was to see these people come back after a few weeks on treatment having gained weight, feeling much better and with fewer symptoms.

People seem to be able to take their medicines very regularly and with few missed doses. While initial side effects were common, most settled in a few days or a couple of weeks. We particularly warned people about the brain effects of Efavirenz to avoid people being concerned that they had become possessed by devils in view of the widely held local beliefs in traditional religions where witch doctors are used to cast out evil spirits, blamed for much illness.

Waiting times at the clinic were sometimes very long, and it was not unusual for people to spend the whole day at the hospital waiting to see the doctor, waiting to collect their prescription, waiting to have further adherence counseling from the pharmacist, and then waiting for a ride home crowded into the back of the local clinic ambulance, which was a closed top utility.

Because HIV has affected a huge proportion of the population there were many children, whose growth was stunted and whose development was delayed. I remember one boy 17 years old, who was 19kg

Once people are known to have HIV infection they are encouraged to have a CD4 cell count drawn to help assess their immune function. These blood tests can only be taken once a week on a Tuesday morning between 7:00 and 11:00 am so people queue from early in the morning to get their place outside the hospital laboratory. If they have that blood drawn at one of the district health clinics they may have to stay in the clinic for the night to have the blood drawn at 6:00 AM to reach the transport deadline. The results take two weeks to come back and then people are seen by the screening clinic nurse who assesses the eligibility for ARVs by the CD4 cell counts and from a brief questionnaire about symptoms of AIDS illnesses. If someone has a CD4 cell count less than 200 or has an AIDS defining illness then they will be eligible for the medication. If it is higher then they return in 3-6 months for another CD4 cell count.

Before they start ARVs they have to attend a 40 minute adherence education session

with the nurse who runs through all the issues connected with taking ARV medicines and the need for good adherence. An HIV viral load and a chest x-ray are done at this point. Many people have TB which may need to be treated first.

The ARV clinic runs in an old portable caravan. The waiting room is some benches under a tree in the shade. They hadn't finished putting the partitions in the caravan so a patient might be seen at one end by the doctor while another person was being checked by the nurse at the other end. In these circumstances anything more than shared confidentiality is impossible. While this may seem rudimentary to us, it must be remembered that many people live their lives in shared huts without solid walls and privacy isn't something people enjoy in the rest of their life.

The doctors prescribe ARVs to a strict formula. The first line of treatment was Combivir and Efavirenz for adults. If a woman was between fifteen and 45 she received Nevirapine instead of Efavirenz. If this line of

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and looked like an 11 year old. He was an orphan living with his aunt and uncle and their five children. His parents had both died a few years before of AIDS. Because he was an extra mouth to feed, he always got less and was forced to use a separate cup and plate at home because his family were mistakenly scared of infection.

The clinic started on the 13th of July, staffed by one of the local doctors each morning, and in the first three and a half months 420 patients started on treatment. This is the outstanding achievement which was based on the system that aimed to maximise the scant human resources by using nurses and health auxiliaries for as many tasks as possible and which tried to base HIV services in the local district health clinics to avoid overloading the already crowded hospital.

There were no patient support groups or people living with HIV organizations working in the local area. This is a major failing of the response in Botswana. While there are national groups based in the capital, their reach and scope is limited to the four major towns. As a doctor working in HIV in Australia I have always found the community groups working in synergy with the medical/scientific community and government to strengthen and broaden our communal response. While I included the development of a local community group in our local implementation plan, the district health team responsible for doing this had not started by the time I left. There are many reasons why it would be difficult to start a patient advocacy group in such a remote environment: people



are so busy just trying to stay alive and the central government, while democratic, does not have a good history of listening to dissent. On the other hand maybe as people start to feel better with the treatments, they will be able to start one themselves. There are district and village AIDS committees, but mostly their membership is drawn from tribal chiefs and powerful people, and their role is to encourage education rather than patient advocacy.

Programs like the one that I had the opportunity to work with for such a brief time are good

examples of what can happen in developing countries with such limited resources and physical challenges. Often from a distance it can all seem too hard, but I think that both the medical and PLWHA communities in Australia can assist developing countries with support and constructive advice, while being aware that cultural differences mean that the local people must develop local programs which suit their needs, rather than adopt lock stock and barrel our version of HIV care.

Treatments Update: what's new, what's changed

Report on the 44th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) in Washington. *By Alan Strum*

Hepatitis C trials shedding light

Two studies were presented on the benefits of Hepatitis C (HCV) treatments in people co-infected with HIV and HCV. The first study from Spain had general entry requirements where people were given treatment with pegylated interferon (Pegasys, an immune modulator) and ribavirin (an antiviral drug) who had a CD4 count greater than 300 and high liver enzyme values that are indicative of liver damage. Preliminary results from 120 people at 24 weeks showed that 66% of people achieved a virologic response including the difficult to treat genotype 1 at 63%. The second study looked at the use of HCV therapy (79% pegylated interferon) similar to the above study in 56 people who had advanced liver damage/fibrosis. Results showed that only 14% of people had a sustained virologic response one year after ceasing therapy and many experienced side effects during treatment with 29% needing to stop treatment and 20% requiring hospitalisation. *[Editor's note: In Australia HCV therapy is only available to people with advanced liver disease. The current guidelines don't take a person's HIV status into account. These data, though preliminary, clearly show that people with HIV need to be treated early while they still have an intact immune system, and they need to be treated before advanced liver disease sets in. Hopefully the Federal Government will understand this soon and change indications for access to HCV therapy that are relevant to people with HIV.]*

Tipranavir: salvage therapy drug shows true colours

The protease inhibitor tipranavir has been the talk of the town for ages about its potential role in salvage therapy. Boehringer-Ingelheim released 24 week results from the RESIST-1 study

at the conference. In this study people were heavily pretreated with anti-HIV drugs. Participants had been exposed to a median of 12 anti-HIV drugs (4 were protease inhibitors). 620 people enrolled into the study. 311 were randomised to receive tipranavir boosted with 200mg ritonavir and 307 were randomised to receive other ritonavir boosted protease inhibitors. Participants had access to T-20 and other antivirals that were matched to their resistance mutation profiles after resistance testing. Drug sensitivity tests to HIV collected from the participants showed that lopinavir, the active component of Kaletra, had a reduced ability to inhibit HIV by 77 fold where as tipranavir sensitivity was only reduced by 1.5 fold. Results clearly showed superiority of tipranavir over other boosted protease inhibitors with 47% of people reaching undetectable levels (less than 400) compared to 22% in the comparator arm. Boehringer-Ingelheim filed for registration of their new drug in the USA and Europe in the last week of October. *[Editor's note: This data far exceeds any of my expectations for a salvage therapy protease inhibitor. Unfortunately we will have a bit of a wait before this drug becomes readily available in Australia. Limited access to tipranavir is available through an emergency use program. PLWHA Victoria and NAPWA are working together to encourage more places for access to this life saving drug.]*

Heat and Kaletra don't mix

Abbott Laboratories have stated that Kaletra is stable at 25 degrees for up to 2 months. In order to find out how Kaletra would stand the test of time in humid and hot climates the National Institute of Health (NIH) in the USA carried out tests on the capsules in high humidity at 35 and 45 degrees. At 35

degrees the Kaletra capsules maintained their shape and drug content at 30 days but by day 60 they had lost their shape. At 45 degrees the capsules became soft and sticky within the first day before finally breaking apart. The amount of the drug in the capsules at both temperatures had become reduced to unacceptable levels by day 60. The NIH recommended that the capsules be made available in blister packs in hot climates and not be dispensed with more than a 30 day supply where refrigeration is not available. *[Editor's note: Keep this in mind next time you go to the beach or put your drugs in the car. If you need to travel with your drugs it is probably a good idea to put them into a cooler bag or a cooled flask etc. Never store drugs in cars where the temperature can reach 65 degrees within a few minutes.]*

GSK enters the CCR5 race

CCR5 inhibitors can effectively block HIV entering cells. There were previously only 2 companies with data on CCR5 inhibitors but now GSK have thrown their hat into the ring with results from their drug currently called 873140. Phase I/IIa dose ranging and safety data were presented on 40 treatment naive and experienced patients, 8 of whom had HCV co-infection. The most effective dose of 600mg twice daily reduced the viral load by 1.6 log. Side effects were considered to be transient within the first few days and included loose stools (poo), tummy pain and nausea. The next study for this new drug is planned for early 2005.

Quad nuke therapy shown to work

In 2003 triple nuke combination therapy (drugs like AZT) went into a bit of a nose dive after the release of data showing that Combivir (AZT/3TC) + efavirenz was significantly better than

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Trizivir (AZT/3TC/abacavir). 48 week results from a UK study in 113 people has shown that Quad nuke therapy consisting of Trizivir + tenofovir is as effective as Combivir + efavirenz. In a second study, presenters reported on Trizivir and tenofovir as an effective second line treatment in people who had viral rebound from their first treatment consisting of AZT or d4T + 3TC + an NNRTI (drugs like nevirapine) or a protease inhibitor (drugs like Kaletra), with 65% of people achieving an undetectable viral load (< 50 copies) at 24 weeks. [Editor's note: *There are advantages for using drugs from the one class as this helps to avoid drug interactions and complications with lipodystrophy (fat accumulation) while sparing drugs from other classes for use later on. While this data looks good, I would be suggesting that it is important to look at long term toxicity studies as all 4*

drugs presented in these studies have an ability to cause mitochondrial toxicity that has been associated with lipoatrophy. Interestingly, no data on body fat changes were reported in these studies.]

Kaletra and tenofovir interaction

Previously, studies in treatment naïve people have shown that it is okay to take Kaletra and tenofovir together. However, a drug level study in 18 treatment experienced people has recently shown that tenofovir can decrease lopinavir, the active ingredient in Kaletra, by 34% (C_{min}), and reduces ritonavir by 44%. The researchers advised that therapeutic drug monitoring may be necessary in people taking Kaletra with tenofovir to determine whether an increase in the Kaletra dose is required. [Editor's note: Kaletra has pretty much revolutionised the success

of HIV treatment. Its track record in reducing viral loads is more than impressive. I think we will have time to sort out what this information means given the small number of people in this study and Kaletra's track record at reducing viral loads in the general population. For now we will need to wait and see how this data is interpreted by the experts.]

Abacavir hypersensitivity

A Seattle study of 50 people who were being treated for primary (acute) HIV infection with an antiviral combination containing abacavir, has shown that hypersensitivity (allergic reaction) to the drug was as high as 18%. Hypersensitivity to abacavir in chronic HIV infection has previously been documented at only 5% in clinical trials. The investigators advised that abacavir should be avoided in people with primary HIV infection (seroconversion illness).

Conference Report on the 7th International Congress on Drug Therapy and HIV Infection, Glasgow, 14-18 November 2004.

By Alan Strum

The Glasgow Conference held every two years is a favourite among Australian doctors with nearly 50 Aussies attending. The secret to the success of this conference is that the conference organisers have chosen a successful model whereby they only have one stream running throughout the conference that mostly focuses on updating clinicians on all the information that has been presented at other conferences throughout the previous year. As such, it is an excellent conference where everyone can be easily updated on what to start with, switching drug therapies, opportunistic infections and new drugs. There were few surprises at the conference with most information having been presented elsewhere. The conference opened with a sobering reminder that 70 million people had been infected with HIV

since the beginning of the epidemic, with 38 million currently living with HIV. What to start with was a general review of nucleosides and which are the best for commencing therapy with the least toxicity. There was certainly a trend of opinion that once daily drug backbones such as either tenofovir with 3TC or FTC, or abacavir with 3TC would become more popular in the near future, especially given the convenience of the new combination tablets becoming available. There were a few points of interest that I picked up along the way. What stood out the most for me was the number of new drugs that are now in development, of which, many will work against resistant virus in heavily pretreated people or will work at totally new targets to inhibit the virus. The next 5 years should see totally different

drug choices become available that will change the way HIV is currently treated. In one case study presented, a man who had received numerous treatment regimens and had never achieved an undetectable viral load was placed into the protease inhibitor TMC114 study with T-20. He started out with a CD4 cell count of 5. After commencing TMC114 that works against resistant virus, he achieved an undetectable viral load for the first time ever and his CD4 cells started to go up.

The following are some highlights from the conference:

Tipranavir 24 week data: RESIST 2

Pedro Cahn presented 24 week data on the new protease inhibitor, tipranavir, in 863 treatment experienced people. People were separated into two

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groups; those who would be taking tipranavir versus those taking other ritonavir boosted protease inhibitors (with optimal background therapy). 11.5% of participants in the study had access to T-20. The tipranavir dose was 500mg + 200mg ritonavir twice daily. 41% of people in the tipranavir arm achieved a greater than 1 log reduction in viral load versus 14.9% in the comparator protease inhibitor arm. Side effects were similar between the two groups.¹

2 year atazanavir data

The BMS 045 2-year study results were presented looking at 237 people taking d4T + 3TC with either ritonavir boosted atazanavir or Kaletra. Participants needed to have failed at least one previous protease inhibitor. At the end of 2 years, 56% of people were still taking atazanavir while 53% were still taking Kaletra. The reduction in viral load was similar between the two groups. There was significantly less diarrhoea experienced by people taking atazanavir (3% vs 13%) who also experienced significant reductions in triglycerides and cholesterol. However, those taking atazanavir also experienced increases in bilirubin levels, a breakdown component from red blood cells, which resulted in 7% jaundice (yellow skin) and 3% with yellow eyes (this is not considered to be clinically relevant as the increase in bilirubin does not appear to interfere with any physiological functions of the body).

Abacavir + 3TC fixed dose combination tablet

A study was presented on a phase III study of 260 people looking at the efficacy of the new once daily combination tablet containing abacavir (ABC) with 3TC. All participants had been initiated on twice daily ABC and twice daily 3TC with either an NNRTI (drugs like nevirapine) or a protease inhibitor (drugs like Kaletra) as the third agent, and a viral load less than 400 copies for at least 3 months. 130 people were

changed to the once daily ABC/3TC combination pill. At 24 weeks the once daily combination tablet was equivalent in efficacy to the comparator twice daily tablets. Adherence improved in the group taking the combination tablet and there were no differences in side effects between the groups.²

Early resistance testing

Mark Wainberg presented data from 31 people in Canada who had been recently infected with HIV. He tested each person for resistant virus and found that 10 had resistance and with 6 resistance to multiple drugs with up to 15 mutations. People who had been infected with resistant virus tended to have lower viral loads and their virus did not revert back to the original wild type (natural/non-resistant) virus. One person became infected with a second HIV virus that was also resistant to other HIV drugs. Dr Wainberg advised that resistance testing should be done on all patients prior to starting HIV drugs to ensure the drugs will work for them.³

Kaletra – 6 years on and still strong

6 year results of Kaletra (lopinavir with ritonavir) with d4T and 3TC were presented in a poster by RM Gulick. The study initially enrolled 100 people who had never taken antiviral treatment. By the end of 6 years there were still 63 people in the study who had undetectable virus. Over the six year period the mean CD4 cell count increase was 529 cells (increasing from an average of 280 to 808 cells). Those people who initiated treatment with less than 50 CD4 cells experienced an increase from an average of 23 cells to 576 cells. The most common side effects reported over the six years were diarrhoea (28%), nausea (16%), lipodystrophy (13%), and abdominal pain (10%).⁴

Kaletra Clinical Experience

An observational study of 1278 people on Kaletra in France were presented in a poster. 75% of

people achieved an undetectable viral load over 9 months (<400 copies). Lipids such as cholesterol and triglyceride only rose within the first month and then remained stable for up to 9 months. There was a low rate of discontinuations at 8.9% (63 people) of which only 31 people stopped treatment due to side effects from the drug.⁵

Deca Durabolin study

Prof Julian Gold from the Albion Street Centre in Sydney presented 12 week results from an ongoing international study using either Deca Durabolin (nandrolone decanoate), Testosterone or Placebo in 303 people with HIV who had lost 5-15kg in the last 12 months. This is the first study of its kind measuring the benefits of Deca Durabolin over an 18 month period that will provide information to clinicians on how best to deal with HIV wasting. Results showed that people taking Deca Durabolin had better improvements in lean body weight (muscle) and quality of life than the placebo or testosterone groups.⁶

New saquinavir film coated tablet

Roche presented data on their new 500mg film coated saquinavir tablet. The tablet proved to be (bio)equivalent to the old 200mg hard gel capsules when boosted with ritonavir.⁷

Syphilis and HIV

Fiona Mulcahy presented information on syphilis and HIV. There are an estimated 12 million cases of syphilis each year. Outbreaks have been occurring in a number of countries and have been associated with men who have sex with men with high-risk sexual behaviour, high rates of partner change, low condom use and frequent use of drugs around the time of sexual activity. Syphilis and HIV appear to both increase the spread of each infection with 20-70% of people diagnosed having both infections. Data was presented that showed that syphilis increases the CCR5

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receptor numbers on the surface of CD4 cells that make it easier for HIV to enter and infect the cells, ultimately speeding up the HIV disease process and increasing the viral load. Further to this, *Libois* presented information showing that high numbers of people with HIV have already progressed to Neuro-Syphilis (21%) upon initial presentation, indicating that presumptive treatment of neuro-syphilis may be appropriate in the HIV patient setting.^{8 9}

Tenofovir 144 week results

The tenofovir 903 study results were presented of in 600 antiviral naïve people with 3TC + efavirenz with either tenofovir or d4T. People taking tenofovir experienced significantly more growth in limb fat that continued to improve over the 144 week period, whereas those on d4T had only marginal improvements. Triglycerides (blood fats) continued to rise for those taking d4T while there were no increases for those taking tenofovir. Changes in kidney function were similar among both groups (2-4%). LDL (bad) cholesterol increased more in people taking d4T while HDL (good) cholesterol was higher in people taking tenofovir. Both arms had similar decreases in viral load and increases in CD4 cell counts.¹⁰

Concomitant use of ddI with tenofovir

The T-20 Toro study results were evaluated to explore the efficacy of the ddI + tenofovir combination when used as part of the optimal background therapy chosen for people in the study. 113 people were evaluated who were taking ddI + tenofovir versus people taking either tenofovir without ddI, ddI without tenofovir and those not taking tenofovir or ddI. The standard dose of ddI (400mg) was used with tenofovir which is acknowledged as being too high given the drug interaction that takes place between the 2 drugs that increases the amount of ddI exposure in the body. Results clearly show that those people

taking ddI with tenofovir did not do as well immunologically as those taking other combinations i.e. the CD4 cell count did not increase as much as the other arms. The poor immune response was not related to virological failure. Those taking T-20 along with ddI and tenofovir experienced a CD4 increase for only 8 – 12 weeks which then did not increase any further while CD4 cells in the other arms continued to increase out to 48 weeks.¹¹ The blunted CD4 response is thought to be caused from a drug interaction between tenofovir and ddI which causes a decrease in the DNA building blocks required to make new cells (there were suggestions that falls in CD4 cells identified in other studies with this combination may be related to the higher dose of ddI used).¹²

Desmond Maitland presented data on a patient group from the Chelsea and Westminster Hospital that had taken efavirenz with either ddI + tenofovir or ddI + 3TC. 77 people began treatment prior to the early closure of the study due to a poor response to treatment in the ddI + tenofovir arm which displayed a 12% treatment failure rate compared to no failure in the ddI + 3TC group at 12 weeks. All patients had been 100% adherent to their medications. The patients who experienced incomplete treatment viral suppression had an original CD4 cell count of < 200 and a viral load of >100,000 copies.¹³

No interaction between tenofovir and nelfinavir

Boffito presented a drug interaction study looking at the effects of tenofovir on nelfinavir in 32 HIV-ve adults. The study showed that tenofovir does not interact with nelfinavir.¹⁴

Atazanavir switch study

A German study of 32 antiviral pretreated people investigating the benefits of switching to atazanavir with tenofovir and other background drugs was presented. All patients had a minimum of 3 prior antiviral

regimens and had high cholesterol and triglycerides. 30 people completed 24 weeks of the study which showed that switching to atazanavir and tenofovir either maintained or improved viral load suppression along with decreasing cholesterol and triglyceride levels.

Improved viral control

A study from Finland has shown that viral control has improved in a clinical cohort of HIV positive people taking antiviral therapy from 60% of people achieving an undetectable viral load (<50 copies) in 1998 (n=152) to 89% in 2003 (n=356).¹⁵ [*Editor's note: This is an excellent example of how the drugs have become more potent and easier to take since the early days of taking antiviral drugs.*]

Potent new NNRTI results

TMC125 is a new NNRTI that has been developed to have activity against HIV that is resistant to the current NNRTIs such as nevirapine and efavirenz. The problem with the current NNRTIs is that they are all cross resistant with each other i.e. once one stops working they all stop working. TMC125 is the first drug of its kind which will allow sequencing of NNRTIs. In an early study of 7 people presented in a poster, TMC125 reduced the viral load to less than 500 copies in all participants at some point during 48 weeks of treatment. All the participants had documented resistant to efavirenz. There was an average 1.4 log (>90%) reduction in viral load after 48 weeks and an average 1.23 log reduction after 96 weeks in those who remained in the study.¹⁶

CCR5 inhibitor drug interactions

There were a few posters that investigated drug interactions between the new CCR5 inhibitor, UK-427,857, and some other antiviral agents. In a study of 11 people there was no interaction with tenofovir.¹⁷ In study with 12 people, UK-427,857 was increased in the presence of atazanavir or ritonavir boosted atazanavir with the investigators

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recommending that UK-427,857 be reduced 50% when used with these drugs and other protease inhibitors (as shown in previous studies discussed in the abstract).18

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In the news

By Alan Strum

Abacavir once daily

Abacavir is now approved for use in Australia as a once daily medication. This means that people will have the choice of taking either 300mg abacavir twice daily or one 600mg abacavir once daily. A once daily combination pill of 3TC with abacavir is already available in the USA but is not expected to be available in Australia until later in 2005.

FTC approved in Australia

FTC (emtricitabine or Emtriva) was approved by the Australian Drug Evaluation Committee on 8 October for the treatment of HIV infected adults in combination with other antiviral agents. FTC is the 'big brother' of 3TC. It has the same resistance profile as 3TC but appears to have a

longer half life (hangs around in the body longer than 3TC), meaning that it may be a little more forgiving when people are late taking their pills. FTC, produced by Gilead, still requires approval for listing on the Pharmaceutical Benefits Scheme before it will be available at HIV pharmacies.

DDI goes generic in the USA

Barr Laboratories has announced the Food and Drug Administration in the USA has approved their generic version of the drug ddi. DDI, otherwise known as didanosine or Videx EC, was originally introduced to the HIV market by Bristol-Myers Squibb back in the early 90s. Barr Laboratories plans on launching the drug onto the US market immediately.

Syphilis and oral sex

Until recently Chicago had the highest rate of syphilis in the USA. A survey of 627 people diagnosed with syphilis between 2001 and 2002 has determined that 20% of infections occurred through oral sex among gay men.

HIV immune boost

French and Brazilian researchers may have found a way of increasing the body's immune response to HIV. 18 PLWHA not on treatment had immune cells (monocytes) collected from their blood that were chemically treated to change them into a specific type of immune cell called dendritic cells. Dendritic cells can alert the immune system to infection. The dendritic cells were then

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exposed to their own HIV that was chemically deactivated. When the immune activated cells were placed back into each person's body there appeared to be an improved immune response to HIV resulting in up to a 1 log (90%) decrease in viral load and an increase of 100 CD4 cells in 8 of the 18 participants. The increase in CD4 cells lasted for one year before returning to baseline. The other 10 participants also had a reduction in viral load that was not sustained. It appears this form of treatment increased the number of HIV specific CD4 cells along with enhancing the activity of CD8 cells that could recognise and kill HIV infected cells.

Film coated nelfinavir not coming

Roche have announced that the new 625mg film coated nelfinavir tablets will not be introduced in Europe due to manufacturing difficulties. The film coated tablets were to reduce the pill burden from 5 tablets twice daily to 2 tablets twice daily and are easier to swallow. The tablets, which were already available in the UK through a special licensing scheme, are being phased out of the scheme and patients are being advised to use an alternative treatment. The regular 250mg nelfinavir tablets are still available in Europe and the UK. However, in the USA where Pfizer owns the license to nelfinavir, the 625mg film coated tablets will continue to be supplied as they do not have the same manufacturing problems that Roche have experienced. Nelfinavir will continue to be available in Australia in the old formulation (5 tablets twice daily) only.

New role for protease inhibitors?

Australian researchers in Queensland have discovered that saquinavir is just as effective as chloroquine at inhibiting growth of the parasite that causes malaria in test tube studies. Indinavir and ritonavir also inhibited growth of the parasite. The researchers hypothesised that the protease inhibitors may inhibit a protease enzyme in the parasites that are used to digest haemoglobin from red blood cells.

Revised US treatment guidelines

The US treatment guidelines are regularly revised to keep up to date with new clinical trial data. Tenofovir with either FTC or 3TC has been placed on the list as a preferred potential backbone for HIV treatment. *[Editor's note: It's only a matter of time before abacavir makes it onto the US list as a backbone for HIV treatment in combination with 3TC. With these newer, less toxic and easier to dose drugs being recognised within treatment guidelines, older drugs like AZT will most likely be saved for later treatment regimens.]*

PREP starts in the USA

The Centre for Disease Control (CDC) in the USA has provided US\$3.5 million in funding for a Pre-Exposure Prophylaxis (PREP) study in Atlanta and San Francisco. 200 HIV negative men who have sex with men will be enrolled in each city to determine whether tenofovir is safe to use among MSM and whether taking the drug would increase unsafe sex and the incidence of HIV in the study participants. The study has a placebo (fake pill) arm so those

involved won't know whether they are taking tenofovir or the placebo. As the numbers in the study won't be high enough to determine whether taking tenofovir daily can significantly reduce the risk of HIV infection the CDC will be conducting larger studies in Botswana and Thailand to increase the power of the data collected. Should anyone contract HIV during the 2 year study, researchers will determine whether the strain was resistant to tenofovir. All participants will be regularly counselled on the benefits of using condoms. *[Editor's note: In the absence of an effective HIV vaccine the concept of PREP becomes quite enticing, especially in countries where HIV is endemic. For example, in Botswana the incidence of HIV among adults is reported to be as high as 40%. Even if PREP only reduces the risk of transmission by 50% it could save a lot of lives in these countries. PREP is a political and ethical mine field. Thai activists have now become involved in the ethical dilemmas and have provided a press release indicating the injecting drugs users (IDUs) in the Thai PREP trial are not going to be offered clean needles and syringes in the study as they are illegal in Thailand. Furthermore, IDUs may be coerced into the study due to a lack of access to health care based on government restrictions and prejudices shown towards IDUs in Thailand.]*

While very small studies have shown that PREP can be effective in preventing HIV transmission in animals, there is nothing to indicate that it will be effective in humans. It will be interesting to see what comes

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out of these studies over the next few years. For now PREP is something that should only be used within the context of a clinical trial.]

HIV maturation inhibitor

Panacos Pharmaceuticals have released the first results from a proof of principle study using a single dose of their maturation inhibitor, PA 457, in humans. Maturation inhibitors are a whole new class of anti-HIV drugs that inhibit HIV in the last stage of its life cycle. After a single dose of PA 457, the HIV viral load was reduced by 0.7 log. These results, along with results from a 10 day study, will be presented at next years Conference on Retroviruses and Opportunistic Infections in February. *[Editor's note: A 0.7 log reduction after one single dose is very impressive. This creates an expectation from a scientific perspective that multiple doses over time should not only be very potent but will probably be even more potent than many of the drugs that are currently available.]*

WOMEN'S SECTION

Gender, race and hepatitis affect on drug therapy

A study presented at the 7th International Congress on Drug Therapy in HIV Infection on 190 people who had never taken antiviral drugs designed to investigate differences in drug therapy among men, women gender and hepatitis B or C status was presented. The drugs used in the study were once daily or twice daily Kaletra with tenofovir and FTC. There were 41 women in the study and 34 people with either hepatitis B or C. No differences in efficacy, safety or tolerability were detected among the different sub-groups of the study. However, women experienced lower increases in triglycerides than men.

Conception and HIV

A few presentations at the 7th International Congress on Drug Therapy in HIV Infection discussed methods of conception for sero-discordant couples wanting children. Simona Fiore from the Institute

of Child Health in London presented information on sperm washing for HIV positive men to have children with their HIV negative partners. In vitro fertilization and a sperm washing technique was used for 600 couples wanting children. 242 babies were born with no episodes of transmission occurring. However, it was noted that these techniques were expensive, ranging from USD \$10,000 to \$15,000 per procedure (this may be cheaper in Australia). A second controversial study was presented by Pablo Barreiro from Madrid where the HIV positive person was provided with antiviral drugs. When the positive partner achieved an undetectable viral load, unprotected intercourse was advised but only during the most fertile days of ovulation. 75 babies were conceived by 74 couples with no HIV transmission to either partner or baby. All couples were counselled on the risk of HIV transmission.

Free Wills

PLWHA Victoria offers members a limited* free will-making service via De Ayers.

For further information, please contact Mark Thompson on 9865 6772 and he will arrange for De to get in touch with you.

*Service covers up to six beneficiaries and no provision for setting up trusts, fund management or the like.

T-cell Variety Hour

The radio program on


HIV - AIDS

NEW TIME

NEW DAY

Thursdays 8pm to 9pm

**JOY Melbourne
94.9 FM**

 The Victorian AIDS Council/Gay Men's Health Centre



Acknowledgement

PLWHA Victoria would like to thank our sponsors for providing unrestricted educational grants to fund Poslink and Treatment Interactive Events in 2005.



Membership application

All details contained herein will be treated strictly confidentially.

I wish to become a member of People Living With HIV/AIDS Victoria and to receive all privileges of said membership. I agree to abide by the Rules* of the organisation at all times. I give permission to receive information from PLWHA Victoria.

Please **Full Membership:** I am HIV positive and am able to provide verification of this if required.

Associate Membership: I do not wish to disclose my HIV status, I am HIV negative or I do not know my HIV status.

Signed _____ Name _____

Address _____ Postcode _____

Telephone (optional) _____ E-mail address (optional) _____

Please fax or post your membership application to: PLWHA Victoria

6 Claremont Street
South Yarra VIC 3142
Tel: 03 9865 6772
Fax: 03 9804 7978

*Copies of the Rules of the organisation are available from the PLWHA Victoria office.

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